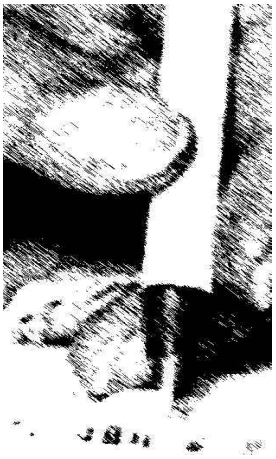
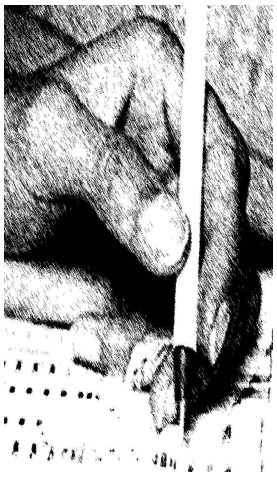
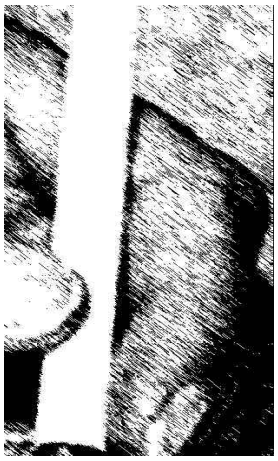
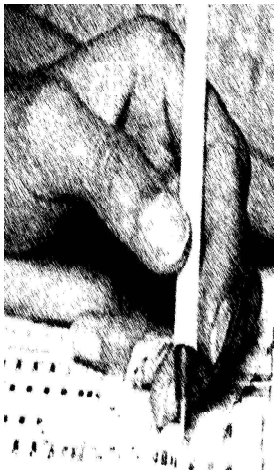


The Utah Health Data Committee 2000 Biennial Report

Accomplishments, products and future challenges of the Health Data Committee and the Office of Health Care Statistics

Published by the Utah Office of Health Care Statistics, November 2000

UTAH HEALTH DATA COMMITTEE
MISSION STATEMENT

The mission of the Utah Health Data Committee is to support health care reform initiatives through the collection, analysis, and public release of health care information.

Through public-private collaboration, the Committee will participate in the development and implementation of a statewide health data reporting system capable of providing accurate and independently validated information in a timely way.

The committee will implement policies to transform data into objective baseline, trend, and performance measurement information which will be made available to all legitimate users without compromising patient privacy and confidentiality.

Adopted 1994

Data Products

Public Data Sets
- Hospital Inpatient
- Ambulatory Surgery
- Emergency Department

Research Data Sets
- Hospital Inpatient
- Emergency Department

Annually Published Statistical Reports

Internet Health Data Query System

Consumer Oriented Guides and Brochures

Users of the HCS Data

Consumers
Employers
Insurance
Government
Utah Hospital Association
Health care providers (e.g. physicians, hospitals, health organizations)
Health care consulting groups
Health Policy Commission
Researchers
Utah Department of Health
Office of Public Health Assessment
Bureau of Emergency Medical Services

Uses of the Data

- To support quality improvement activities that have helped reduce costs and/or promote quality
- To promote provider accountability and competition
- To provide data that can be used by consumers, health providers and policy makers to analyze utilization, costs and outcomes
- To provide unbiased information that allows all users of health care to make better health decisions

Acknowledgments

This report was prepared by the Office of Health Care Statistics under the direction of the Utah Health Data Committee.

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This report, and other Utah HDC reports and databases can be accessed through the Office of Health Care Statistic's Website: **www.healthdata.state.ut.us**

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"According to users of the data, the information produced by HDA does provide a public benefit by helping control costs and promoting provider accountability. Consequently we believe the legislative purpose for which HDA was created is being fulfilled."

-- Legislative Auditor, February 1998

THE UTAH HEALTH DATA COMMITTEE
2000 BIENNIAL REPORT

Section I: Executive Summary

Report Summary

This report reviews the major activities and accomplishments of the Utah Health Data Committee (HDC) and the Office of Health Care Statistics (HCS), which serves as staff for the Committee. The report is submitted pursuant to and in compliance with a statutory requirement for submission of a biennial report to the Utah legislature. This Executive Summary begins with an overview of activities and accomplishments from November 1998 to October 2000. This overview is followed by descriptions of the background and brief history of the HDC, and Office of HCS and present and future challenges faced by the committee. The remainder of the report contains more detailed description of the most important activities and accomplishments from November 1998 to October 2000.

During the two years covered by this report, the HDC has made major strides in: 1) fostering partnerships in Utah, nationally and in the Department of Health for collection, analysis and dissemination of health data 2) incorporating, developing and improving means for electronic submission, processing, storage and analysis of health care encounter data 3) developing a variety of methodological strategies to more effectively analyze available encounter and survey data 4) collecting and disseminating information on Utah's HMOs to support consumer decisions and 5) expanding its ability to transmit both its data and research findings to a broader network of public and private entities as well as consumers.

Accomplishments and Impact

1. HDC has enhanced dissemination of data and research findings to public and private entities and consumers through expansion of the Office of Health Care Statistics' Website. Use of the Internet allows rapid access to timely health information for organizations and to support the decisions of private consumers.

    - The Office of Health Care Statistics Web Enablement Team was awarded the Governor's Chief Information Officer (C.I.O.) award for technology in 1998, in recognition of their work in facilitating the accessibility of health information through the development of Internet linked interactive data bases.

2. The Utah Health Plan Performance Measurement Plan was developed to meet the increasing demand for information on HMOs. During the past two years, HCS conducted a series of surveys and published reports that produced information on HMO performance for consumers, businesses and policy makers. Work included two Enrollee Satisfaction Surveys of Medicaid HMOs with expanded scope. A new satisfaction survey of enrollees in the new Child Health Insurance Program (CHIP) was conducted in 1999. A survey of Medicaid HMO enrollees with special health care needs was also conducted. HEDIS performance measurement data from Medicaid and Commercial HMO's were collected and analyzed in 1998 and 1999. A major survey to assess the satisfaction of consumers with prepaid mental health plans has been designed and data are currently being collected.

- Public reporting on HMO performance has prompted efforts to improve performance by the HMOs.

- The HDC's Performance Measurement Plans has enabled Medicaid and the Child Health Insurance Program to evaluate its inititives to contract with HMOs to provide care.

3. Made extensive improvements in managing three important health care encounter databases, including hospital discharge, emergency department, and ambulatory surgery. These improvements included the design, verification, and implementation of computer programs to receive, evaluate, edit and merge EDI data submitted by hospitals into the statewide databases. The improvements allowed the Office of Health Care Statistics to collect two new databases during a period when staff resources were reduced. Public availability of hospital, ambulatory surgery, and emergency department data have contributed to Utah's Health Care System in important ways. These data allow evaluation of health care practices, contribute to public health survaillanc and identify opportunities for improvement.

    - Hospital discharge and emergency department data identified the impact of medical errors and adverse outcomes.

4. Electronic Data Interchange (EDI) is an emerging technology that can allow more timely collection of data on a wide spectrum of health care encounters. The HDC conducted a pilot project on Electronic Data Interchange in partnership with the Utah Statewide Immunization Information System (USIIS). The project evaluated the feasibility of receiving immunization data electronically from public and private providers.

    - The project allowed HCS staff to contribute to an important state priority, the USIIS immunization registry and improved the capability of HDC and HCS to collect other health care data in the future through the Utah Health Information Network (UHIN).

5. The HDC published a series of reports based on Utah hospital discharge and emergency room data that focused on a variety of health care issues including aggregate and average hospital charges, quality indicators of hospital patient care, patient, provider and clinical profiles associated with the top 50 Diagnosis Related Groups, child and adolescent hospitalizations, Cesarean section deliveries, utilization of emergency rooms and their roles as a pathway to hospital admission and hospital profiles for Ambulatory Care Sensitive conditions for 61 economically homogeneous geographic units in the state. A consumer guide to Utah hospitals was also published.

    - Reporting on Cesarean Section rates and variation in those rates stimulated hospital-based interventions to prevent unneeded c-section procedures.

6. The Office of Health Care Statistics used probabilistic linkage software to exploit the potential of public health data bases in addressing public health surveillance issues. HCS has also begun to link hospitalization and death certificate data, to allow hospitals and others to assess the longer term outcomes of health care procedures.

    - This methodology has enabled HCS to make important contributions in child immunization, computation of HEDIS measures, maternal post-birth readmissions, and integration of the USIIS immunization registry with the Women, Infants and Children (WIC) program's immunization data.

7. The Office of Health Care Statistics participated in the development of small area analysis of health data, and especially hospitalizations. The use of this methodology yielded a profile of 61 economically homogeneous geographic units and a profiling of Ambulatory Care Sensitive hospitalizations across

these communities. Those analyses provide information on health care procedures at the community level and identify ways Utah communities can further improve the performance and outcomes of their health care systems.

- The community level data have been used extensively by the Salt Lake Valley Health Department in its efforts to improve access to healthcare.

8. Expanded partnerships with the Healthcare Cost and Utilization Project (HCUP), a Federal-State government and industry partnership to construct a standardized, multi-state health data system, and with the National Association of Health Data Organizations (NAHDO), an organization dedicated to strengthening the nation's health information system. These collaborations will allow comparisons between Utah's health care system and those of other states that can help identify areas for improvement in Utah. For example, Utah rates of back and prostrate surgery are substantially higher than elsewhere in the U.S.

- Utah's pioneering work has contributed to a multistate information system.

Background and Brief History

The HDC was established in 1990 by the Health Data Authority Act (26-33a) to "collect, analyze, and distribute health care data to facilitate the promotion and accessiblity of quality and cost effective health care". The first priority was a statewide hospital discharge data system and Utah was one of the first states to establish such a system (1992).

In 1996, S.B. 171 empowered the HDC to issue comparative report cards. Public reporting on HMO performance began in 1996 and has since been expanded. The HDC partnered with the Medicaid and Child Health Insurance Programs (CHIP) to assure that consistent and efficient performance reporting occurred.

A 1998 Legislative audit confirmed the value of the data collected by the HDC, both for the public and for the industry. However, the Legislature reduced the general fund budget with the intent that increased sales of data make up that decrease. An increase sufficient to cover that decrease was not possible. The reduction has impaired the ability of the HDC to undertake new initiatives to meet increasing consumer concerns about the Health Care System. In addition, the sale of individuals' data to fund a public good, raises concerns about privacy and public trust.

Partnership with Medicaid

The Division of Health Care Financing in the Department of Health administers the State/Federal Medicaid program, which provides health care coverage for many vulnerable populations in Utah, including the disabled, poor mothers and children and others. Increasingly, the Medicaid programs contract with Utah's HMOs to provide that health care coverage. The Medicaid program has used the expertise of the Health Data Committee and the Office of Health Care Statistics staff to conduct Satisfaction Surveys and collect performance measure data from HMOs. These efforts assist the medicaid program to negotiate value as well as cost in its HMO contracts and provide information to assist medicaid recipients in choosing their HMO. This informed choice stimulates the HMOs to devote more attention to quality.

Future Challenges

The Health Data Committee has overcome substantial hurdles to establish effective hospital care, emergency department and HMO performance data systems. Due to the HDC's leadership, Utah became a leader in collection and dissemination of information about its health care system. America's health care system has continued to evolve rapidly and during 1999 and 2000, upward cost pressures have returned. The Committee faces challenges if it is to continue to build on its successful record.

1. Developments in Electronic Data Interchange (EDI) offer the potential for more efficient collection of data and for obtaining data from outpatient settings where that is not possible today. However, rapid change in response to federal HIPAA guidelines regarding privacy and data standardization, will challenge Utah's health care system and the Health Data Committee. Change provides both opportunity and risk. The HDC, with effective leadership, political support and resources can use this opportunity to shape a new and more robust health care information infrastructure for Utah's citizens, or it can be swamped and left behind by rapid changes.

2. Articles discussing consumer and business concerns about health care appear daily in U.S. newspapers and other media. Although the data collected by the HDC have been well used (as determined by the 1998 legislative audit), many consumers and business purchasers continue to make decisions without the information they need and want. The HDC must reexamine how it markets the information it has assembled, what information products it produces, how those products are packaged and positioned, and who they are targeted to.

3. The value of HDC information has sometimes been limited by the lack of reporting on specific health care providers, health plans, doctors, hospitals and others. The HDC will work with the providers where performance is being measured to assure that the information is valid. Once this has been achieved, the HDC will need political support to release that information for consumers' benefit.

4. Although access and quality attract attention, cost remains the aspect of the health care system of most concern to many. The HDC has been hampered in its assessments of cost by the lack of availability of data on actual reimbursement (as apposed to charges). This needs to be corrected. In addition, the main driver of recent cost increases has been pharmacy expenditures about which data are not currently collected.

5. The Health Data Committee has successfully overcome technical obstacles in the past and can face the challenges described above. All these challenges require technical and other resources, however. Currently the Committee has insufficient resources to accomplish its mission. The Committee believes that its mission provides public good not otherwise supported by marketing forces and which should be funded by government sources. However it must attract additional resources in some way- from business uses of the data, foundation or government grants, or Utah's Legislature- if it is to accomplish its mission.

Section II: Highlights of HCS's Accomplishments

Health Care Encounter Databases Hospital Discharge, Emergency Department, and Ambulatory Surgery

1999-2000 Accomplishments

- Since 1992, there has been an ongoing compilation of inpatient hospital discharge data that is comparable to other state and national hospital databases.
- Since 1996, there has been an ongoing compilation of emergency department data in partnership with the Bureau of Emergency Medical Services.
- Since 1996, there has been an ongoing compilation of ambulatory surgery data from hospital-based and freestanding surgical centers.
- Extensive improvements in the data editing process have been designed and implemented to improve the database validity.
- Extensive improvements have been made in the computer programs that receive data from the hospitals, check them for systematic errors, and merge them into the statewide databases.
- Several reports on these databases, discussed elsewhere, have been published and distributed.

2001-2002 Plans

- Continue to improve the data editing and data management processes.
- Implement a data editing process where data errors for each hospital can be downloaded to a spreadsheet, reported to the hospital in a spreadsheet, corrections made in the spreadsheet by the hospital and returned to the Office of Health Care Statistics, and uploaded to the database. Currently errors are reported on paper.
- Further evaluation of the option of obtaining data via the Utah Health Information Network (UHIN) and the feasibility of receiving data from hospitals and other health providers in this manner.
- Improve the timeliness of data availability.
- Link hospital data with death certificates to allow assessment of three month and one year mortality of these procedures such as coronary or leg bypass grafting.
- Produce information and reports based on the data targeted at specific user groups, individual consumers and business purchasers of health care coverage.

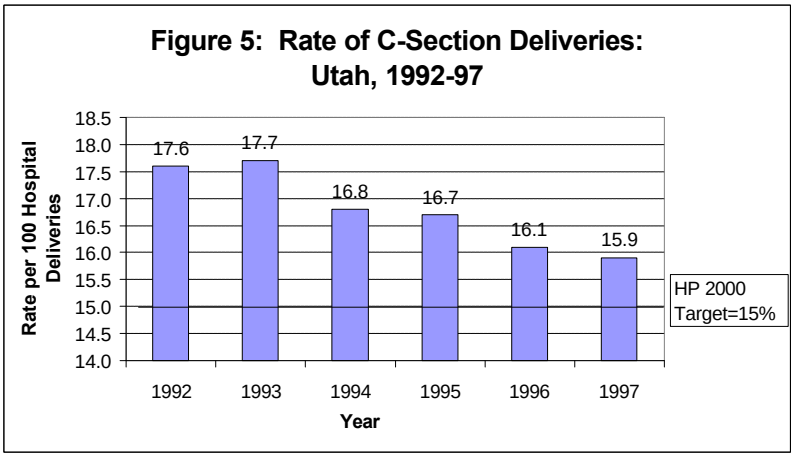
Reports

The HDC and the Office of Health Care Statistics published a series of reports on a variety of health care issues, using data from Utah hospitals discharges, Utah emergency room visits, Health Plan Employer Data and Information Set (HEDIS), and HMO Performance Survey.

These reports addressed issues such as prevalence of important illnesses affecting Utahns (numbers, rates etc.), aggregate and average hospital charges, quality indicators of hospital patient care, patient, provider and clinical profiles associated with the top Diagnosis Related Groups, child and adolescent hospitalizations, Cesarean section deliveries, utilization of emergency rooms and their roles as a pathway to hospital admission and hospital profiles for Ambulatory Care Sensitive ACS conditions for 61 economically homogeneous geographic units in the state.

Those analysis provided information on ACS and other illnesses and conditions at the community level and helped identify ways Utah communities can further improve the outcomes of their health care systems. Ambulatory care sensitive conditions are conditions that should rarely require hospital care if good outpatient care is accessable. High rates of hospitalization indicate problems. These data were used by the Salt Lake Valley Health Department when it convened a community coalition to improve the health care "safety net". They also facilitate tracking of trends in hospital care and health care practices, such as changes in hospital length of stay prompted by managed care pressure. The following is an example of how timely dissemination of health care data on important public health topics can help identify opportunity for improving health care delivery.

Cesarean Section Deliveries in Utah Hospitals
(an example of how hospital discharge data stimulates improvement in care)



Utah made national news for being a state with the lowest C-section delivery rate. On August 29, 2000, The Associated Press released a national news story (reported by the *Salt Lake Tribune*) reporting a C-section rate of 22 percent of live births nationally, with large variations among the states:

"Fewer than 17.5 percent of births in Utah, Wisconsin, Colorado, Alaska or Vermont are C-sections. But more than one in four births are C-sections in Mississippi, Louisiana, Arkansas and New Jersey."

This news story was preceded by a report published by the Office of Health Care Statistics using six years of hospital discharge data. The report was made publicly available in printed form and on the Internet.[1] The impetus for the report was the concern that C-sections were being performed unnecessarily, leading to high cost, longer hospital stay, and unnecessary morbidity. The Office's report showed that Utah was steadily moving closer to and nearly achieving this objective, as shown in the above graph.[2] It also identified substantial variation in practices among hospitals.

The public availability of this information to both health care providers and health care consumers, has stimulated Utah physicians and hospitals to examine practices regarding C-sections. These efforts should help prevent unnecessary C-section deliveries and lead to further, appropriate reduction in the rate of C-sections performed in our state. This type of public health monitoring is an example of how the Utah Hospital data are being used to improve health care delivery and public health in Utah.

Reports produced by Office of Health Care Statistics.

A list of selected reports produced by Office of Health Care Statistics under HDC's guidance is as follows:

1. "*1998 Selected Quality Indicators of Hospital Patient Care in Utah*" (2000)HCUP-3 Provides updated measures of indicators of quality of care in Utah's hospitals using Utah Hospitals Inpatient Discharge Database, 1992-98. Quality indicators provide information about outcomes of inpatient care, especially surgical procedures; utilization of inpatient services, which reflect physical practice patterns, and physician-patient decision making; and access to care in community, through ambulatory care sensitive conditions.

2. "*Top 50 DRGs with the highest number of discharges in 1998: Patient, Provider and Clinical Profiles*" (2000). Diagnosis Related Groups (DRGs) are nationally standardized categories that reflect the type of patients treated by hospitals and type of services received by those patients. Variation for top 50 DRGs by volume is analyzed by patient characteristics, co-morbidities, and hospital characteristics.

3. "*St-1 1998 Utah Hospital Inpatient Discharge Data Standard Report I*" (2000) This standard report on Utah hospital utilization and charges profile contains hospital level details on volume and intensity of patient care, hospital level differences in inpatient care, by patient demographics and complexity, using Utah Inpatient Discharge Data, 1998.

4. *"Utah Hospital Inpatient Admission Through Emergency Department Utilization and Charges Profile: Statewide Summary, 1997." EDAR-2:97 (Emergency Department Annual Report 2)*. (2000).

5. "*Utah Emergency Department Utilization and Discharge Profile." EDAR-1:97 (Emergency Department Annual Report 1)* (2000).

6. " *Child and Adolescent Hospitalization for Most Frequent and Expensive Conditions in Utah."* (1999). Depicts regional and community level (small areas) patterns of hospitalization of Utah children and adolescents (ages 0-19) for conditions that are among the most expensive and frequent. Utah Hospitals Inpatient Discharges Data 1993-97 were presented using graphs, maps, and summary tables.

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[1] The Associated Press, *C-section rates on the rise again*, August 29, 2000, Internet site: "www.quadcityonline.com/national/acsect.html".
[2] Office of Health Care Statistics, *Cesarean Section Deliveries in Utah Hospitals, 1992-1997*,Salt Lake City, UT: Utah Department of Health, 1999.

7. "*Cesarean Section Deliveries in Utah Hospitals, 1992-1997".* 1999. Contains an impressive review of previous studies on cesarean deliveries, and indications for cesarean deliveries. The latest information about indications of c-section, c-section rates and trends, and patient and hospital characteristics associated with higher c-section rates is presented.

8. *"Small Area Analysis of Hospitalizations for Ambulatory Care Sensitive (ACS) Conditions in Utah, 1992-1996."*1999. A ground breaking work on small area analysis which identifies 61 economically homogenous geographic units of optimum size and lays foundation for subsequent small area analysis. Ambulatory care sensitive conditions are illnesses that are sensitive to the kind of outpatient care received by people in communities.

9. Informational Brochure: *"Utah Medicaid HMOs: A Report Card for Consumers*," October 1999. The information includes satisfaction survey results of Medicaid HMO enrollee and HEDIS measures.

10. "*Medicaid Prepaid Mental Health Waiver Renewal Report*", submitted to HCFA 1999. Evaluation of Medicaid prepaid mental health programs using encounter data.

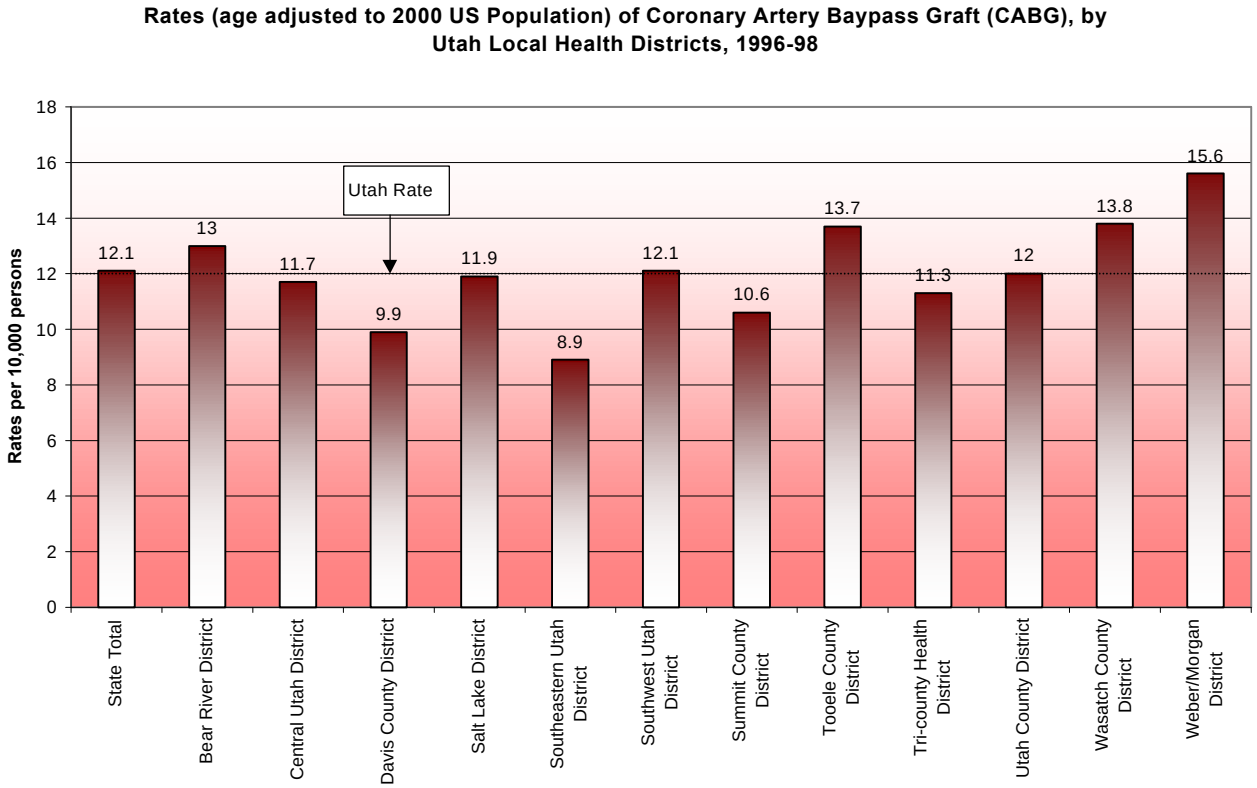
11. Hps1— *1998 Satisfaction Survey of Enrollees in Utah HMOs -Comparison of Respondents and Responses Between Medicaid Beneficiaries and Commercially-insured HMO Clients* (1999)

12. *Utah Hospital Consumer Guide*: *1997 Average Inpatient Hospital Charges for Utah's MostCommon Conditions Requiring Hospital Admission.* (1999)

13. 1996 Utah Hospital Financial Data. (1999)

In addition to reports printed on paper, HCS produces updated tables for many previously published reports and publishes them on the Internet. Pertinent findings from occasional projects are also posted as data highlights. A graph from one such data highlight is given below:

Coronary Artery Bypass Graft (CABG)



The complete story on coronary artery bypass graft (CABG)" in Utah can be viewed at:
http://hcs.editthispage.com/stories/storyReader$7

Internet Projects 1999-2000

IQS

Continual improvements to the Health Information Internet Query System (IQS). IQS is software that enables users to query health care databases to produce user defined summary tables or graphs of simple statistics.

Development of MACHIIM site

- Supported by a three-year grant from the Federal Maternal and Child Health Bureau, Maternal and Child Health Information Internet Query Module (MaCHIIM) was created to enhance the UDOH's existing UDOH Internet-based health data query systems.

- HCS's staff made significant contribution in developing this interactive query system.

- The MaCHIIM system is created at two levels of detail. The first sub-module contains basic on-line informationin the form of static graphs, tables and bullets. The second sub-module generates on-line MCH statistics interactively based on questions asked by users.

- Four other states have adopted MaCHIIM's transportable applications. The MaCHIIM has the potential to greatly improve maternal and child health (MCH) care surveillance and planning capabilities at the local/community and state levels.

To see this Internet-based maternal and child health information query system, please follow the following URL: http://hlunix .hl.state.ut.us/matchiim/main/

The technology developed as part of the partnership that produced MaCHIIM, will be used in the next year to update the HDC Internet Query System.

Design for HCUP Website

Convenient on-line ordering function added to Website

In June 2000 the office implemented an easy on-line order form that allows users to preview reports and view data set field descriptions before purchasing them.

Site redesign

The HCS Website has been redesigned allowing users easier more intuitive navigation of the site.

Reports standardized online

All HCS published reports are now available on-line as in the adobe acrobat format. The PDF format makes it easy for users to print, download or read the reports on-line.

Health Care Statistics Enablement project won the 1998 governor's CIO award
The Office of Health Care Statistics Web Enablement team was recently awarded the Governor's Chief Information Officer (CIO) award for technology for 1998. The winners of this award exemplify best practices in the design and implementation of Information Technology systems and promote efficiency and effectiveness in state government. The award was to acknowlege that theproject team used state of the art, Internet connected, interactive databases to make health information available to Utah's citizens, researchers and the medical community in the state.

Utah Health Plan Performance Measurement

1999-2000 Accomplishments:
1. Results of the 1998 and 1999 Enrollee Satisfaction Surveys of Medicaid HMOs were published and released to the public.
2. Scope for both 1998 and 1999 surveys expanded to include Medicaid Fee-For-Service clients and HMO Point-Of-Service clients.
3. Satisfaction Survey of Medicaid HMO Enrollees with special health care needs
4. Satisfaction Survey of CHIP Enrollees
5. Collection of 1998 and 1999 HEDIS measurement data on commercial and medicaid HMOs
6. Currently a Satisfaction Survey of Prepaid Mental Health Plans is being conducted by an independent vendor.
7. Currently the 2000 Consumer Assessment of Health Plans Study (CAHPS) survey of enrollees in medicaid and commercial HMO's is being planned and will be conducted in early 2001

2001 Plans:
1. Satisfaction Survey of HMO enrollees will follow NCQA protocols and schedule to improve its quality
2. Satisfaction Survey of Medicaid clients with special health care needs
3. Satisfaction Survey of CHIP enrollees
4. 2000 HEDIS data collection - a collaborative effort for quality improvements is currently in process with the UDOH, Diabetes Control Program and USIIS (Immunization Registry).

Publications:
1. Special Report: *1996-1998 Satisfaction Survey of Enrollees in Utah HMOs*
2. *1998 Utah Medicaid HMOs: A Report Card for Consumers*
3. *Compare Your Utah Medicaid HMO Choices: An HMO Health Care Report Card that shows the 1998 Consumer Survey Results & 1997 HMO Performance Measures*
4. *1999 Utah Medicaid HMO Performance Report: How to Compare HMOs - 1999 Consumer Survey Results & 1998 HMO Performance Measures*

Utah Health Plan Performance Measurement Plan

Background
With the aim of providing meaningful data to help Utah consumers, businesses and other purchasers of health care, and policymakers make informed decisions about health care, the Utah Health Data Committee implemented the Utah Health Plan Performance Measurement Reporting System in 1996. The performance measurement system is comprised of enrollee satisfaction surveys and Performance measures based on the Health Plan Employer Data and Information Set (HEDIS).

In order to provide dependable data and to fill the information gap between the rapidly expanding HMO industry and Utah consumers and policy makers, the Utah Health Data Committee has been working closely with HMOs, Medicaid, policy makers, and public health officials over the past four years. In 1998, the Health Data Committee passed two administrative rules (R428-12 and R428-13), requiring all health plans in Utah to report audited HEDIS measures data and participate in enrollee satisfaction survey. The data collected through these two rules provide a starting point for a public reporting system that meets the needs of multiple audiences. As a result of the Utah Health Plan Performance Measurement Plan, Utahns now have substantially more information on which to build their health care decisions.

Enrollee Satisfaction Survey

Since 1996, both commercial and Medicaid HMOs have participated in the Utah HMO enrollee satisfaction survey. The survey questionnaire was developed by the Utah Health Data Committee and interviews were conducted by telephone.

Some 2,200 enrollees of six Medicaid HMOs and another 2,200 clients from six non-Medicaid health plans participated in 1996 satisfaction survey. In 1997, enrollees from all five Medicaid HMOs (2,724 clients) and 2,800 clients of eight commercial HMOs were surveyed.

Starting from 1998, the Utah HMO enrollee satisfaction survey used a modified version of the Consumer Assessment of Health Plans Study (CAHPS) instrument, developed and tested by Harvard Medical School, Research Triangle Institute (RTI), and RAND in sponsorship with the Agency for Health Care Policy and Research (AHCPR). The survey also was expanded to include Medicaid Fee-For-Service (FFS) clients in rural areas as well as commercial Point-Of-Service (POS) enrollees.
Some 3,200 Medicaid clients and 3,613 enrollees of commercial HMOs completed the interviews in 1998. In 1999, about 3,300 Utah Medicaid clients were surveyed along with some 3,400 commercial HMO enrollees.

In 1999, the Utah HMO enrollee satisfaction survey was further expanded to include Medicaid HMO enrollees with special health care needs. Some 2,300 Medicaid clients with special health care needs were included in the survey. In addition, satisfaction survey of 1,244 CHIP enrollees was conducted in 1999. Satisfaction surveys for Medicaid enrollees with special health care needs and for CHIP enrollees are planned to be conducted once in every two years.

HEDIS Collection

The Utah Health Date Committee has been collecting data on HMO performance, Health Plan Employer Data and Information Set (HEDIS) , since 1996. HEDIS was developed by the National Committee of Quality Assurance (NCQA), to meet the needs for Health Plan data, expressed by business leaders. In accordance with R148-13, Utah HMOs are required to contract with an NCQA-certified audit agency to verify their HEDIS measure data prior to the HEDIS submission. HEDIS, the most prominent of efforts to develop a standardized set of health plan performance measures, of: 1) clinical quality of care, 2) utilization of services, 3) access to care, 4) patient satisfaction, 5) financial performance, 6) general plan management, 7) cost of care, 8) membership, and 9) network affiliation and structure.

Four commercial HMOs and three Medicaid HMOs submitted HEDIS data in 1996 and 1997. In 1998, more plans participated in HEDIS collection to include five commercial and five Medicaid HMOs. Currently, the 1999 HEDIS from five Medicaid and five commercial plans is being compiled.

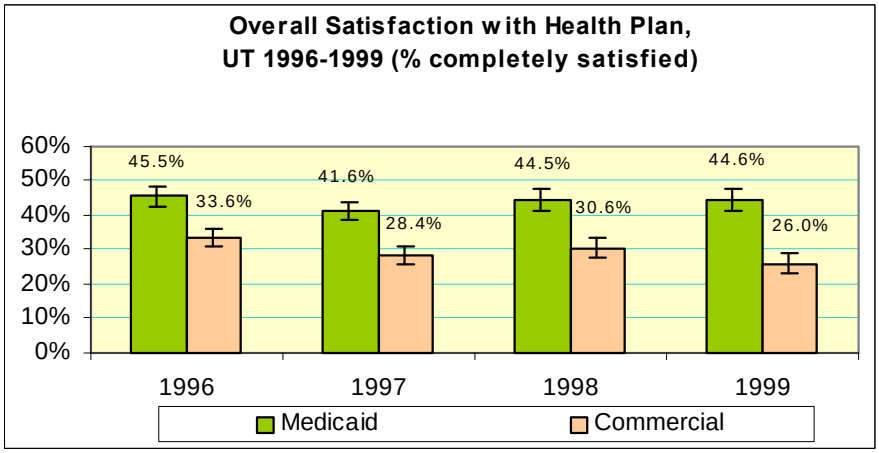
Current Status
2001 enrollee satisfaction survey is in the process of planning by the Office of Health Care Statistics (OHCS). The survey will interview people who were continnuously enrolled for on year in Medicaid and commercial HMOs during 2000. The 2001 survey will use the unmodified CAHPS2.0H survey instrument but its methodology will be changed from all telephone to mail and telephone. With these changes, Utah survey results will be standardized and comparable with other states' and national CAHPS survey results.

As originally intended with the implementation of Utah Health Plan Performance Measurement Plan, all licensed Utah commercial and Medicaid HMOs will be participating for 2001 survey and 2000 HEDIS collection.

As another attempt at collaborative effort for quality improvement, OHCS, the Utah Diabetes Control Program (UDCP), and the Utah Statewide Immunization Information System (USIIS) are currently exploring the possibility of consolidated HEDIS collection. Utah health plans have been submitting subparts of HEDIS to UDCP and USIIS while submitting the complete set to OHCS. The consolidation effort will provide a foundation for the quality check of HEDIS and reduce the cost and burden of for HMOs and for the UDOH.

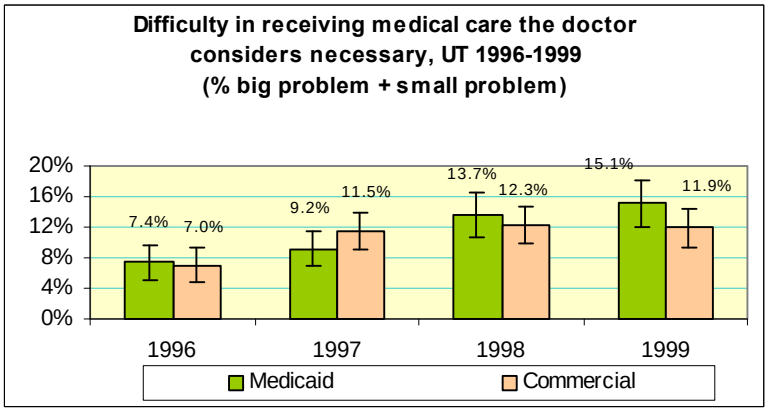
Performance Measurement Results - major findings

Overall Plan Satisfaction



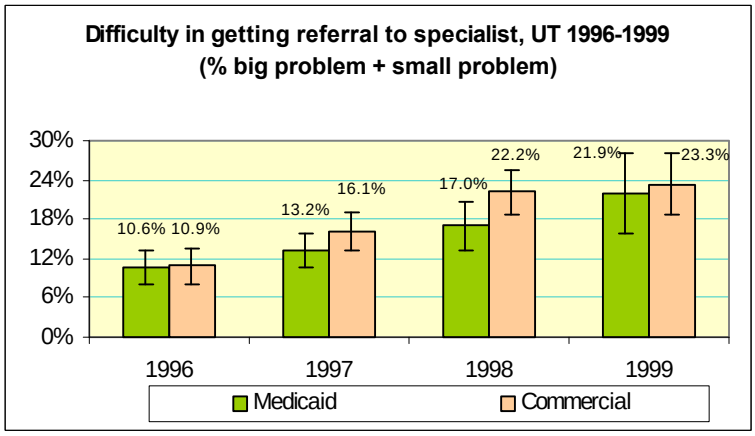
During 1996-1999 period, the overall satisfaction with health plan has been rated higher for Medicaid HMOs compared to commercial ones. The proportion of those who were completely satisfied decreased somewhat for commercial plans.

Problems Getting Needed Medical Care



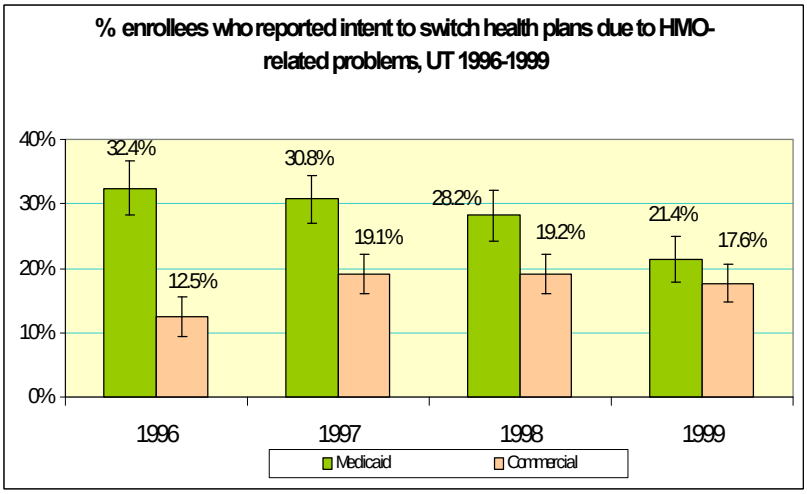
The proportions of Utahns reporting difficulty receiving needed medical care increased from 7% to 12% for commercial enrollees and from 7 % to 15% for Medicaid enrollees.
Overall the increase is somewhat larger for Medicaid plans.

Problems Getting Referral to Specialist



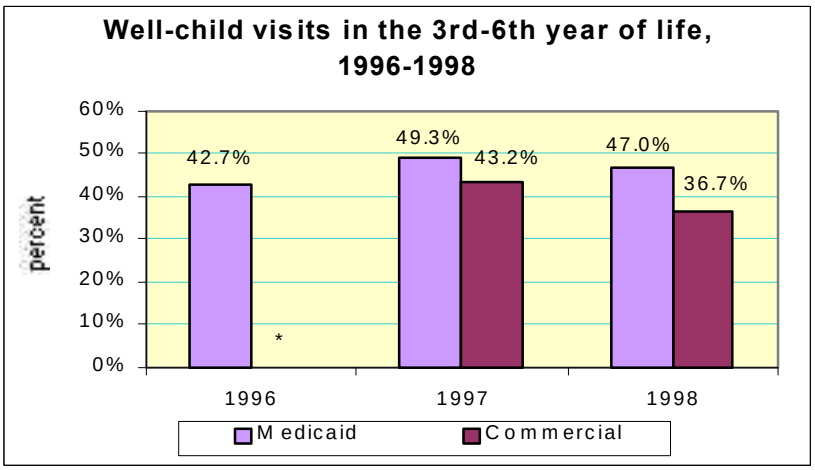
The percentage of Utahns reporting difficulty getting referral to a specialist increased from 11% to 23% for commercial enrollees and from 11% to 22% for Medicaid clients.
Between 1996 and 1999, commercial enrollees reported slightly more problems than Medicaid enrollees.

Intent to Switch Plans



Medicaid enrollees were more likely to report that they intended to switch health plans due to problems. That difference decreased over time.

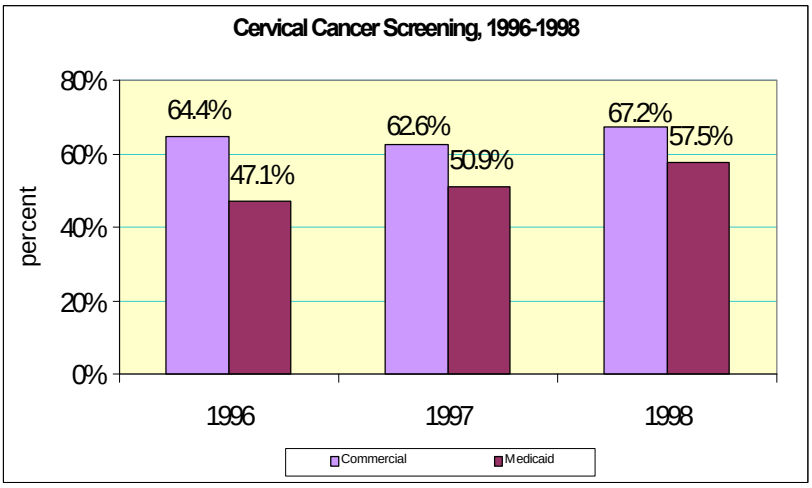
Well Child Visits (Age 3-6)



* In 1996, data for commercial health plans were not reported.

For children age 3-6 years of age in Medicaid HMOs, the percentage with at least one well-child visit in the preceding year increased from 43% in 1996 to 47% in 1998. The percentage for commercial HMOs decreased slightly in 1998.

Cervical Cancer Screening



HEDIS indicated that 67% of women 21-64 years of age in commercial HMOs and 58% of those in Medicaid HMOs had received a Pap test in the past three years. The rate of the Pap tests increased among women in Medicaid HMOs between 1996 and 1998.

Electronic Data Interchange (EDI) Pilot

Background

- In its commitment to facilitate collection of quality data, the Health Data Committee conducted a pilot project on Electronic Data Interchange (EDI) in partnership with USIIS (Utah Statewide Immunization Information System) from August 1999 to July 2000.
- The purpose of this pilot project was to assess the feasibility of receiving immunization data electronically through UHIN (Utah Health Information Network) and to develop the capacity for an ongoing collection of immunization data using EDI.
- Another more relevant objective of the pilot for the Office of Health Care Statistics (HCS) was to determine the feasibility of ongoing collection of other databases such as Inpatient Discharge Data, using this Electronic Data Interchange (EDI) mode.

Purpose

- This pilot project was conducted pursuant to a request from USIIS to collect immunization data from private clinics for USIIS. The request followed a strong recommendation from the USIIS Ad Hoc Advisory Committee, providers, and the project evaluator for the development of an electronically based system for transmission of the immunization records of public and private providers to the USIIS immunization registry.
- The pilot was important in that many private providers' immunization records were not available electronically. Therefore those immunization records could not be included in the USIIS system.

- Since most private providers already used UHIN for electronic exchange of their billing data to insurance companies, no additional burden was placed on private providers. The simultaneous electronic transmission of a carbon copy of the immunization data to the USIIS registry via UHIN eliminated the need for duplicate data entry by private providers.

HCS's Role

- HCS drafted and negotiated the contract for this pilot project and obtained the final signatures.
- Although some of the project's operative functions, such as retrieving data from UHIN mailbox and translating it into ASCII format, were subcontracted to Health Care Finance Division (HCF), HCS assumed responsibility for the complete oversight of the project including validation of the electronically exchanged immunization data.
- The EDI contract with UHIN covers not only the current project ; future EDI transactions through UHIN are covered as well. The protocol developed and used in this pilot project will serve as a guideline for future EDI of administrative data transferred through UHIN by clinics and hospitals.

Partnerships:

- Healthcare Cost and Utilization Project (HCUP), a Federal-State-industry partnership to build a standardized, multi-State health data system. HCUP is maintained by the Agency for Healthcare Research and Quality (AHRQ). Website: " Utah submits data elements from both its inpatient and ambulatory surgery databases. Currently 22 states submit inpatient data and nine states submit ambulatory surgery data.
- National Association of Health Data Organizations (NAHDO), an organization dedicated to strengthening the nation's health information system. It serves as a broker of expertise for the development and enhancement of statewide and national health information systems. Website: The NAHDO Website includes an Emergency Department Internet Query System, which is modeled after the query system on our own Internet Website and uses a copy of our emergency department database as example data. This encourages other states to adopt the same query system and data elements, making it possible for everyone to perform uniform hospital data queries with other states easily on the Internet.

Utah Benefits from Partnerships with National Health Data Efforts

The Health Data Committee is participating in partnerships with several national efforts to collect, combine, and report on hospitalization data. Within-Utah data provide comparisons between Utah hospitals, creating a market force to improve care and reduce costs to the level of the most efficient provider in Utah. Comparisons of data between states, however, create a market force to improve care and reduce costs to the level of the most efficient state in the nation. By participating in these national data partnerships, this larger market force is possible.

Partnerships:

1. Healthcare Cost and Utilization Project (HCUP), a Federal-State-industry partnership to build a standardized, multi-State health data system. HCUP is maintained by the Agency for Healthcare Research and Quality (AHRQ). Website: "www.ahrq.gov" Utah submits data elements from both its inpatient and ambulatory surgery databases. Currently 22 states submit inpatient data and nine states submit ambulatory surgery data.

2. National Association of Health Data Organizations (NAHDO), is an organization dedicated to strengthening the nation's health information system. It serves as a broker of expertise for the development and enhancement of statewide and national health information systems. Website: The NAHDO website at"www.nahdo.org/nahdo/index.html", includes an Emergency Department Internet Query System, which is modeled after the query system on our own Internet website and uses a copy of our emergency department database as example data. This encourages other states to adopt the same query system and data elements, making it possible for everyone to perform uniform hospital data queries with other states easily on the Internet.

Challenge - measuring the actual cost of care:

After several years of moderate increases due to the cost control effects of managed care, health care costs have begun to increase at rates well above the rate of inflation. The Health Data Committee has been limited in tracking and disseminating information on costs because hospitals report only charges, not what was actually paid for care. Managed care organizations often receive substantial deductions from those charges. The collection of actual cost data from providers has been controversial and is an ongoing challenge for the HDC.

Section III: Response to Legislature's Budget Cut and Funding Challenges

In fiscal year 2000, the Legislature cut the general funds appropriated specifically to the Office of Health Care Statistics (formerly, "Office of Health Data Analysis") with the expectation that the Office could make up the difference by increasing sales of its products and services.

The budget cut was initially proposed in 1998, upon the Legislative Auditor General's Office recommendation that the Office obtain at least one-half of its general revenues of $500,000 from the "health care industry". Specifically, the 1998 Appropriations Bill states:

"*It is the intent of the Legislature that the Office of Health Data Analysis becomes self sustaining through the sale of its data, published reports, products or services to all business, insurance, research or commercial entities to the greatest extent possible. Fees derived from the sale of these products and services shall be sufficient to generate one-half of the operating budget by the beginning of fiscal year 2000."*

The following table displays how the Office of Health Care Statistics was funded during the past three years.

Table: Office of Health Care Statistics Revenues by Source

Fiscal Year	General Funds	Data Product Sales	Contracts	Contract Sources
1998*	$500,000	$34,880	$226,178	Health Care Finance (Medicaid)
1999	$509,000	$58,835	$161,906	Health Care Finance, Bureau of Emergency Medical Services
2000	$286,000	$79,076	$316,443	

*July 1, 1997 to June 30, 1998

The Office was able to increase its ability to accomplish the Committee's work by obtaining contracts for projects that overlapped the Committee's mission. However, each of these contractual projects were primarily focused on the needs of the contracting organization rather than on the work of the Committee.

The lost revenue has substantially reduced the ability of the office to carry out the work of the Committee in the following ways:

- Insufficient resources to package and target the information to potential users.
- Inability to undertake promising new initiatives such as collection of data through the Utah Health Information Network (UHIN).
- Inability to replace aging computer resources which will seriously impair the office in the future.
- Difficulty maintaining timely production of data bases, which is critical both to the Committee's work and to its ability to raise revenue through sale of data.

The Office and Committee are continuing to explore both new sources of revenue and ways to increase efficiency and productivity given current resources. However the Health Data Authority Act was passed because the health care market did not support the provision of information needed by consumers, business purchasers and policymakers. That situation has not changed so it isn't likely that the market will financially support the HDC or its work. The data collected by the HDC and the information provided from those data, are a public good that will not be produced by market forces alone. As such, they should be supported in large part, by public funds through the Utah Legislature.

HCS Background

The Utah Health Data Authority Act (26-33a) enacted in 1990, established the Utah Health Data Committee and defined its purpose to "collect, analyze and distribute health care data to facilitate the promotion and accessibility of quality and cost-effective health care and also to facilitate interaction among those with concern for health care issues". The Legislature expanded data collection activities through H. B. 305 in 1995 and inserted "report card" intent language into the Utah Health Data Authority Act in 1996 with S. B. 171. In this rapidly evolving health care industry, transformed by managed care and competitive pricing pressures, a source of objective, nonproprietary, and comparable information is essential to measure and monitor the quality of and access to care for all Utahns.

The first priority of the Health Data Committee was to establish a statewide hospital discharge data system. Hospital data provide important information about illness experienced by Utahns, and the quality of care they receive, and can help assess whether timely and appropriate ambulatory care is uniformly accessible. Hospital care also comprised 38.5% of health expenditures in Utah in 1998.

Utah was one of the first states to establish a statewide hospital discharge database (1992) and a pioneer in using the Internet to disseminate those data. Utah is now one of 21 states that partnered with the Federal Agency for Healthcare Research and Quality (AHRQ), to create a data source that allows between-state comparisons. Thus the pioneering work of the Utah's Health Data Committee is contributing to an emerging national health information infrastructure.

The Office of Health Care Statistics sought to implement the legislative intent to cover the cost of the Health Data Committees mission through revenues from users of the data. That has not proven possible, however. Revenues from sale of data products increased (from FY 1998 to FY 2000) by aggressive marketing of the data, but the increase covered only about one quarter of the loss in general funds. The legislative audit suggested that the data were valuable to providers (especially hospitals) and that those providers had paid for collection of hospital data by the Utah Hospital Association previously and should pay for its collection by the HDC. However, the hospitals collected the data for their own use and not for public use.

HDC/HDA 1990-1998

The Health Data Committee's work since 1990, can be divided into several stages, listed below:

1990-1993:

The committee established a vision, mission, and priorities. A public process was established for planning, and technical capacity of hospitals was assessed.

1993-1996:

The inpatient hospital discharge data reporting system was implemented, including all-payer hospital encounters from all licensed hospitals in Utah and the Veterans Administration Medical Center. Technical difficulties were solved and processes for validating data and analytic reports, testing different analytic methodologies (e.g. risk-adjustment and peer groupings) were implemented in partnership with hospitals and othere interested parties.

1996-1998:

In 1996, S.B. 171 inserted "report card" intent language into the Utah Health Data Authority Act. The committee went through its first community-wide planning process since 1990 and worked hard to bridge competitive tensions between HMOs to create comparative managed care reports for consumers. During the HMO report card implementation, the committee also oversaw expansion of the inpatient hospital discharge data reporting system to include ambulatory surgery and emergency department encounters and improvement of data quality and the content of reports to include population-based and small area analyses. The Office of Health Data Analysis was retained by Medicaid to implement its managed care reporting system (HEDIS reporting, satisfaction surveys, and encounter data base development).

1998-2000:

A 1998 legislative audit confirmed the value of the data collected by the HDC, both to the public and to the industry. The legislature reduced the general fund portion of the HDC budget by $200,000 with the intent that it would be made up by increased revenue from data users. An increase of that magnitude was not achieved. The Office of Health Care Statistics was able to support some Committee work through partnerships with parts of the Department of Health whose mission overlapped that of the Committee. However the reduction in staff resources impaired the ability of the Committee to undertake new initiatives in response to changes in the health care industry, to maintain timely releases of data, and most importantly to improve the dissemination of targeted information to consumers. The data collected by the HDC are of value to the health care industry, but their greatest value is to the Utah public who depend on that system for their care.